The Hampden Hippocrat

Oct.
Nov.
1984

Vickie Kiss

President 1984-1985
Hampden District Medical Auxiliary

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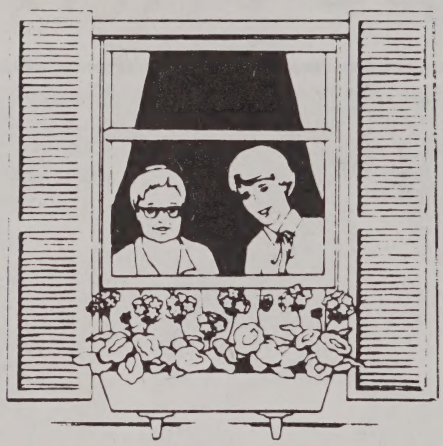

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Baystate Medical Center Surgical Grand Rounds

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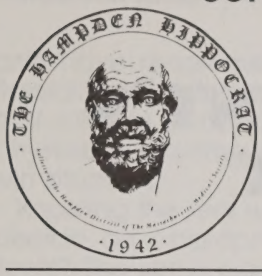
As an organization accredited for continuing medical education, Baystate Medical Center certifies that this CME activity meets the criteria for credits in Category I for the Physician's Recognition Award of the American Medical Association (two hours credit per session).

November 3, 1984 "Vascular Trauma"	**MALCOLM O. PERRY, M.D.** Chief Division of Vascular Surgery New York Hospital Professor of Surgery Cornell University Medical College New York, NY
November 10, 1984 "Surgical Management and Pathophysiology of Benign Gastric Ulcer"	**M. MICHAEL EISENBERG, M.D.** Direcor, Department of Surgery Professor & Vice Chairman Department of Surgery SUNY Downstate Medical Center Brooklyn, NY
November 17, 1984 "Circulating Mediators of ARDS"	**HERBERT B. HECHTMAN, M.D.** Associate Professor of Surgery Harvard Medical School Senior Associate in Surgery Brigham and Women's Hospital Boston, MA
December 8, 1984 "Burn Wound Management"	**ROBERT H. DEMLING, M.D.** Director Longwood Area Trauma Center Associate Professor of Surgery Harvard Medical School Boston, MA
December 15, 1984 "Predictive Factors in Success or Failure of Infrainguinal Arterial Reconstructions: Importance of Outflow Resistance Measurements"	**ENRICO ASCER, M.D.** Attending Surgeon Montefiore Hospital and Medical Center Assistant Professor of Surgery Albert Einstein College of Medicine Bronx, NY

OCTOBER — NOVEMBER 1984 VOL. XXXXI NO. 15



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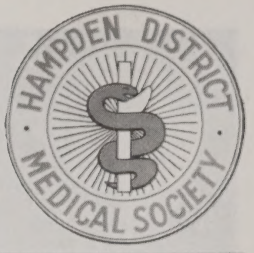

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A.R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED BI MONTHLY.

THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

ALL COMMUNICATIONS SHOULD BE ADDRESSED TO CAROL L. NYSTROM, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109: TELEPHONE: 736-0661.

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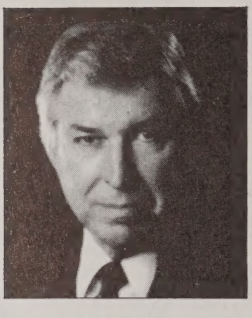

PRESIDENT'S PAGE

Orwell - 1984

Lorne C. Smith, M.D.
President

In his novel 1984, George Orwell accurately predicted the tyranny that would be applied to the citizen of a totalitarian state. His predictions came true a generation ahead of the fictional time table in much of the world. At least half of the citizens of the world live now in a society where "Big Brother" is a real and permanent part of life. Our profession is not excepted. Fortunately ours is still a free society.

It is intriguing that he selected 1984 as the time frame for his novel. His clear perception of the future in 1939 could not include modern information storage and retrieval technology as part of the picture, yet he seemed to perceive such a system being developed.

We now live in the world of electronic information storage and retrieval. The manner in which the computer impacts upon our lives, both personal and professional, is the subject of this essay. Orwell's predictions raise chilling prospects for the future.

Recently, the Health Planning Council of Greater Boston released a detailed study of surgical utilization in Massachusetts. The information was obtained from the Massachusetts Health Consortium Data Bank. The study compared the incidence of common surgical procedures to the expected rate. The expected rate was the average rate state wide. The basis of comparison was a community base, ie., the address of the patient. The report cited those communities with low or high incidence of the particular procedure being performed. the procedures were varied from tooth extraction to colon resection to hip replacement. A final analysis inculded a rating of communities in Massachusetts from 1 to 172 according to how much surgery was performed on patients from each community. Most of the communities in our area ranked between 160 and 172. In some circles concerned with the subject we are now referred to as the "Surgical Captial of the World".

Much of the report is concerned with methodology, possible sources of error, age adjustment, etc. The information concerns 1980 data. The report was released to the media with much accompanying comment. It received a very wide press.

The interpretation of the information in this report has, in the light of time, been completely negative as far as our profession is concerned. Several high ranking officers of the state, both elected and appointed have asserted that much unneeded surgery is being done

and have recommended various remedies. Other segments of officialdom have inferred that some communities are underserved and that citizens in need of care are being deprived of this care. We physicians become the focus of criticism from both sides. It is a true no win situation.

Knowing the real world, many challanges can be made. Who can decide an appropriate rate of tooth extraction for hosptial inpatients? The same can be said for D & C, a procedure almost never performed on an inpatient. How many inappropriate hip fracture reductions, colon resections or prostatectomies are possible? Very few, indeed.

This information is, however, considered important and valuable by a significant number of individuals and governing institutions.

One could make a hypothetical comparison for statistics on motor vehicle deaths by address of the victim. Depending upon one's focus one could assert any of the following factors as being at fault in a community with a high rate: roads, police, driver education, auto repair facilities, bar closing hour, etc. Each could be a factor or none could. Each is subject to public regulation.

Physicians more than any other profession conduct endless inquiries into their performance. Inpatient surgical procedures are reviewed to a degree that little can possibly slip by. Most tissue committees go months between cases that are possible problems. This is obviously not enough. We will have to justify and document all that we do on an ongoing basis.

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It is anticipated that close data bank surveillance will be applied to all the physicians within a few years. One can only imagine with horror the possible consequences such as "I am sorry, Sir, we will not be able to do your operation until next year. We are already over quota for this year and our license for this procedure will be withdrawn if we exceed one standard deviation. If this happens you will be placed in a pool of candidates for the Northeast and will have to go wherever the control data bank schedules the procedure"!

One of the most important and urgent challenges facing our profession in my opinion, is to somehow impact with a strong voice of reason and responsibility upon those who control present and future health information data banks. We must have better representation from the mainstream of medicine upon the governing bodies of the data banks. We must do better than has been the case in similar areas in the past when we left the field of battle rather than pursue a losing cause. Retrieval and distribution of health care data, along with its intrepretation, will have a profound influence upon our practices and upon our lives. We must do what we can to interject at least objectivity.

The Hampden District Medical Society is attempting to establish a better relationship with the Western Mass. Health Planning Council. Mr. Herbert Hooven, its director, came to our last Executive Committee meeting and reviewed this study of surgical utilization with us. He made it clear that this report is being taken very seriously by many. He pointed out that the further one was from the subject, the worse the data looked for us in Western Mass. We will hopefully be able to at least comment upon and, where appropriate, challenge future studies of this sort as they are released. □

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Editorial

The practice of medicine is undergoing protean changes which involve and concern us all. On a daily basis we are inundated with information and opinions. The newspapers are well aware that the activities and controversies of the medical community are devoured avidly by the public at large, and television and radio can daily be observed offering their perspectives. The official bulletin of the AMA and the State Medical Society are instrumental in conveying information of their respective activities. Even the lunch table barracking these days is more often addressed to the effect of HMO's and PPO's than the exploits of the Red Sox or the Rams.

The Hampden Hippocrat has always played its part in this literary profligacy. The President's page, reports from delegates and committees, news and updates, essays by contributing editors have all added to the information barrage.

Where should the Hippocrat go? Firstly, there will be in due course a new format. The 6 x 9 inch size will be replaced by a more standard 8 x 11. It is felt that this will make for easier reading, easier filing for those who wish to keep an article or even a whole issue, and greater flexibility in spacing text with advertisements.

Secondly, we would like to make the Hippocrat much more an organ of communication. There is a great deal of untapped literary talent in the Hampden District. Opinion and counteropinion and thoughtful introspection are often voiced but not often enough recorded. David Page's article in the September Hippocrat is an excellent example. His contemplation of the role of a surgeon in the teaching process is worthy of consideration by those of all disciplines.

Perhaps there are those however who disagree with what he said. Certainly Terry O'Neil's article two months ago raised a considerable furor locally and to the East. We would like to make the Hippocrat a two-way street, open to both approval and opposition of opinion. Essay's such as Dr. Page's are welcome. For those less ambitious or with a more succinct comment, a letter would suffice. Communicants need not even be members of the Hampden District Medical Society. We would like to invite any who agree or disagree to voice their opinions in print.

To be sure this will increase the volume of newsprint that you will have to digest, especially when coupled with the traditional Hippocrat report, news and opinions. But this can be a dynamic process, a true exchange of your views. We hear the discussions at lunch, we hear them at staff meetings, lets hear them in print. Lets keep the Hampden District the vital active group it has always been, and the Hippocrat something to file after reading, not before. □

Nicholas P. Coe, M.D., F.R.C.S.

The Auxiliary 1984-1985

Victoria Kiss
President, H.D.M.S. Auxiliary

The Hampden District Medical Society Auxiliary is the largest medical Auxiliary in the state of Massachusetts. It celebrated its thirty-fourth birthday in 1984. We are proud of where it has been, what it has done and where it is going. You have heard repeatedly about its activities and its presidents; however, the really important people of an organization come from the membership, particularly its board. We are privileged to have on our board the following members:

President Elect: Mrs. Ginny Walthall
Recording Secretary: Mrs. Betty Lynch
Corresponding Secretary: Mrs. Eileen Burke
Treasurer: Mrs. Kathy Mouchantat
Scholarship Treasurer: Mrs. Audrey Botnick
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Membership-Interns and Residents: Mrs. Elaine Alexander
Membership Book: Mrs. Myra Wiedman
Nominating: Mrs. Diana Abbasy
Parlimentarian: Mrs. Alice Cummings
Publicity: Mrs. Helen Gallivan
Seminar: Mrs. Jane Condon

Telephone: Mrs. Helen Siragusa
Mrs. Pat Pacosa
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Shared Concerns Symposium "Quality Medical Life" Mrs. Lorraine Penhose
Shared Concerns Symposium "Financial Planning" Mrs. Ellen McGuire
Holiday Tea: Mrs. Carol Yorzyk
Mrs. Carol Trachtenberg
Mrs. Laura Fernandez
Annual Meeting: Mrs. Diana Abbasy
Mrs. Cynthia Bye
SPECIAL APPOINTMENTS:
Carol Nystrom, Executive Secretary to the H.D.M.S., Advisor
Pat Smith: Nutritional Consultant to the H.D.M.S.

Now you know we have a terrific board and here are the reasons why.

1. We parallel the Hampden District Medical Society but we have our own message.
2. We contribute to our community through our scholarship program, our docent's program at the Springfield Science Museum, our child passenger safety program and health education seminars available to members and the community. We also contribute to the community in that our membership serve and belong to other religious and civic organizations.
3. We keep our members aware of legislation which affects the medical community.
4. We help each other understand the stresses in our marriages that medicine and more importantly medicine in the 80's put upon us. We are a medical "support group" for one another.

However, all is not happy in the garden of eden. This is an age of disenchantment with organizations. There is a loss of membership and a lack of participation. There is a new found worship of the individual. We might try to put it bluntly, find ourselves "hanging separately." During these times of flux, it requires all of us working together to achieve positive change and a positive image of the medical profession. We need each other, knowledgeable, committed to sharing our strengths and weaknesses. We need to commit ourselves to caring, to actions, to solutions and to hope for medicine and the Auxiliary. So if you are a physician, send us your better half. If you are a medical spouse — join us, we can do more together! □

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We Know Where We're Going!

Billie Brady
President
1984-1985 AMA Auxiliary

It is a pleasure to greet you!

When I took office as president of the American Medical Association in June of this year, I brought a message to the members assembled for the Annual Session of the House of Delegates. I told them that now is the time to formalize ideas that were to take place in the future...to make goals a reality...to blend tried and proven ideas with new ideas...to anticipate the opportunities of the years ahead.

I would bring the same message to you. For I have a vision for this 1984-85 auxiliary year. My vision is to increase membership through personal contact, to broaden knowledge and involvement in legislation, to promote the importance of health care, and to raise funds to help ensure the future quality of medical education and research.

We know as we look at medicine's future that a difficult road lies ahead. The practice of medicine is becoming more complex for the physician faced with DRGs, PPOs, HMOs, and the constant threat of a malpractice suit. In 1984-85, we must put more emphasis on the needs of our members who experience these stresses in their lives. We must look after our own and show physicians' spouses that we are the caring, supportive organization that will meet their needs.

We must also become educated on legislative issues that will protect quality medical care. We have the opportunity to exert a concerted force, and only our best efforts will protect the health and welfare of the people of this nation.

We must increase our fund-raising efforts for the AMA Education and Research Foundation to help medical schools meet rising costs and to ensure that quality medical education is available and that scientific and medical research are furthered.

We must continue to work for the prevention of child abuse and drunk driving, to ensure immunization of school children, to promote substance abuse prevention, and to provide services to the elderly. We must also focus on the importance of pre-natal and post-natal care, with education programs on adolescent pregnancy, fetal alcohol syndrome, nutrition during pregnancy, the hazards of smoking during pregnancy, and the proper use of infant auto safety restraints.

To be effective educators, we must go to the uninformed, the troubled, and the at risk. As members of the AMA Auxiliary, we must harness our vision of the future, tackle our problems as an undivided force, and move forward.

John Naisbitt, author of Megatrends, said, "If you have a clear vision of where you're going, it helps you sort out your choices." We know where we're going — to a future that is bright, with a growing membership, increased legislative involvement, expanded funding of medical research and training, and rededication to health care education.

Our vision is not one in which the quality of medical care is sacrificed and eroded, but rather one in which it is sustained and renewed, due in part, to the far-reaching efforts of a unified, strong American Medical Association Auxiliary.

Best wishes for a happy and successful year. □

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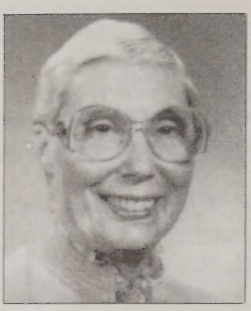

Greetings!

Vi Meeker
President
Massachusetts Medical Society Auxiliary

Greetings to all of you from the Massachusetts Medical Society Auxiliary.

Hampden District Medical Society members should take great pride as I am sure you do, in your auxiliary.

HDMSA programs address the particular needs of medical families, as well as resources and programs for the community. Your auxiliary's continuing interest in health education with the TAM project and the Science Museum as well as the seminar "More Than Survival" for the physician's spouse are but a few examples of the outstanding efforts by your auxiliary. The seminar in March entitled "Abuse and Abuses", a program designed to explore causes, treatment and legal ramifications of physical, emotional and social abuse in your community, will serve as a model for other auxiliaries across the country as a community service program for adolescents.

In conjunction with 5 other health related organizations, your auxiliary cosponsored "Adolescent Parents: A Crisis", a unique example of a cooperative effort in health education for the community. This conference focused on prevention services, programs, education, legislation and effective lobbying, child abuse, research, and evaluation. The HDMSA has continued its work in the field of child passenger safety with an exhibit at the Big E this past year with the Safety Council of Western Massachusetts. Six qualified students from medical and para-medical fields were chosen to receive scholarships with funds raised by your auxiliary. The American Medical Association's Educational and Research Foundation also received a sizeable contribution from the HDMSA.

In addition to a very active auxiliary, many of your members hold important offices in the state organization and enthusiastically support the work of other auxilians by sharing programs and resources.

You have one of the most active and vital auxiliary organizations in the country which is a credit to your medical society and to the state and national auxiliaries.

Best wishes for a very successful year! □

Annual Auxiliary Victorian Tea Party

The Auxiliary's Victorian Tea Party — our purely social and festive annual event — is scheduled for December 4th from 12 to 3 P.M. In addition to scrumptious sandwiches, sweets and friendly socializing, one can shop or browse through our boutiques — featuring gold jewelry, stained glass, holiday greens, candy and more! Ask a medical friend to a tea lunch at Norma Sears' home — 263 Concord Road, Longmeadow. R.S.V.P. to Carol Trachtenberg, 567-0239, 7 - 8 A.M. or 7 - 9 P.M. □

Project Medvote

Let's face it, Medicine is clearly one of the most regulated professions in this country. Officials elected this November will directly impact on health care legislation in the future. One survey concluded that only 60% of AMA members in some communities are registered. Please take time in your busy schedules to have a voice in your future. VOTE! □

CHALLENGE

PHYSICAL THERAPY AND REHABILITATION

OPENING DATE:	August 1, 1984
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Auxiliary Health Education Committee

The Health Education committee of the Auxiliary had a fruitful and active year of 1983-1984. The Transparent Anatomical Manikin (TAM) Theatre opened at the Science Museum in October, 1983. Both taped and live presentations were made weekly through June. Our efforts centered mainly on creating a supplemental teaching program to present with the taped program and also on training volunteers within our group.

Our 1984-1985 efforts will continue in this vein where a very active committee will work closely with the Science Museum to continue teaching programs on the Digestive, Circulatory and Respiratory systems and to develop a new one on the nervous system. These programs are presented mainly to school children from kindergarten to sixth grade. A continuing major focus will be on recruiting and training new volunteers for this important effort aimed at educating school age youngsters about the concept of wellness and their responsibility for their own body and their well being. □

Polly Miller
Susan Burstein
Co-Chairmen

Child Passenger Safety

Our committee has been making plans to promote Buckling Up. We hope to be working with the Safety Officers in police departments around Hampden County to remind the general public of the Massachusetts law. Every child 4 years old and under must be in the safety restraint in a car.

Our 2 bench seats with safety belts and a child restraint are available for displays to your group: PTA, church, Scouts or clubs.

PHYSICIANS: PLEASE REMIND YOUR PATIENTS TO BUCKLE UP.

For information call Debra Calvanese, 567-6485 or Audrey Rich, 737-6431. □

Shared Concerns Symposium - Financial Planning

Circle November 15, 1984 on your calendar. Our Shared Concerns series continues with Financial Planning.

It will cover such topics as personal finances, accumulation of assets for education and retirement, insurance, recognition of assets, estate planning, tax awareness and tax shelters. The program will include workshops.

Our guest speakers will be Alice Lawerence, Robert Levitt and Jacob Robinson. They are all chartered financial consultants.

For an interesting morning join us to hear, "Everything you want to find out about finance and were afraid to ask!"

Program co-ordinator for this event is Mrs. Ellen McGuire, sponsored by the Hampden District Medical Society Auxiliary.

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Auxiliary Scholarship News

After another successful scholarship fund raising campaign in November, 1983, the Auxiliary was able to award six $500 scholarships to five new and one renewal area students pursuing nursing and allied health careers.

Those receiving these scholarships are as follows:

Kathleen Buczyko, West Springfield — Freshman for B.A. in Nuclear Medicine at Quinipiac College.

Anna Gandini, Springfield — Senior for B.S. in Medical Technology at Our Lady of the Elms.

Kathleen Hill, Springfield — Senior for R.N. at St. Francis Hospital School of Nursing.

Heidi Maciorowski, Westfield — Freshman for R.N. at Our Lady of the Elms.

Janice Pandoli, Springfield — Senior for R.N. at St. Francis School of Nursing.

Joan Turnberg, East Longmeadow — Sophmore for B.S. in Medical Technology at Framingham State College.

We will be conducting our annual scholarship fund drive this November. We hope all of you will be as supportive as you have been this past year. The cost of higher education is continually rising and many people are in great need of assistance. The number of applications for our scholarship awards increases every year. This year, out of 160 applicants, we could grant only six scholarships. Please respond to this worthwhile Auxiliary project and give generously. □

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District Meeting

The first meeting of the 1984-85 year was held on Tuesday, September 25, 1984 at the Sheraton West in West Springfield. There were 186 members, spouses and invited guests present. Dr. Lorne C. Smith, President, called the meeting to order at 6:10 p.m.

The minutes of the Annual Meeting held on April 24, 1984 were approved.

Dr. Smith reported on the Physician Referral Service and announced that HDMS is increasing the size of its ad in the Yellow Pages for 1985. The larger ads will be carried in the Springfield and Holyoke directories.

The Public Health Committee will undertake an indepth study of the infant mortality statistics in this area.

There will be a Public Hearing on October 11th on Access Problems for Medicaid Recipients. The meeting will begin at 7:30 p.m. in the Conference Room of Springfield Municipal Hospital.

A Public Hearing on Usual & Customary Fees has been called by Insurance Commissioner, Peter Hiam for November 27th.

Dr. Siragusa gave a brief update on the PRO situation in the state.

Mr. George Roy, Director of Department of Research & Development and Mr. Neil Foley, Director, Department of Government Relations for Mass. Medical Society, discussed the Medicare Reimbursement Contract.

The meeting was adjourned at 7:10 p.m.

Following the Social Hour, Dr. Smith announced that there were thirty members of the clergy present as invited guests to hear Msgr. Lorenzetti speak.

Msgr. Lorenzetti gave the invocation. Following dinner, Dr. Smith turned the meeting over to Dr. James Fitzpatrick, Chairman of the Medico-Religious Committee. Dr. Fitzpatrick introduce Msgr. Dino J. Lorenzetti, who delivered a stirring message on the Nobility of the Physician.

The meeting was adjourned at 9:45 p.m. □

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Implications of the Aging of the Population

Report of the Health Care Delivery System Working Group
June - 1984

BACKGROUND:

The Health Care Delivery System Working Group of the Greater Springfield Health Care Coalition formed a task force in December, 1983, to respond and report re: the impact of the increasing aged population on human resourses in Greater Springfield.

The Task Force on Implications of the Aging Population held its first meeting on January 16, 1984. Membership was composed of a variety of health care providers and planners within Hampden County.

After considerable dialogue, the Task Force defined its missions as follows:

1. To make observations as to what is likely to happen to the elder population by the year 2000.
2. To assess whether the community resources will be adequate to meet the needs of elders by the year 2000.
3. To recommend any changes in the service delivery system for elders that might be needed.

Population targets are those elders residing in Hampden County who are 65 years of age or older.

This report will discuss population trends among the elderly, describe community resources and evaluate their adequacy, summarize the problem and make a number of recommendations for the future. Sources for the information include the Western Massachusetts Health Planning Council's Long Term Care Report, Home Care Corporation of Springfield's Annual Needs Assessment, and the U.S. Department of Commerce booklet, America in Transition: An Aging Society.

SUMMARY OF FINDINGS

It is apparent that most community resources will not be adequate to meet the needs of the aging population as we reach the turn of the century. This is the case in both the institutional and non-institutional segments of the long term care spectrum. As the number of elderly increases the system will have to expand to meet their needs. In addition, cost constraints will make it necessary to explore innovative methods of providing these services.

This report has highlighted non-institutional services including home health care, adult social day care, adult foster care, congregate living and hospice/palliative care. These services support the elderly and allow them to function at an independent level in the community, and, in general, tend to be less expensive than institutional services. It has been shown that the current supply of these services will be inadequate to support the potential demand. For example, there is only one congregate living facility and only one social day care

program, and the existing hospice/palliative care programs are limited in scope. Areas such as home health care, home care, and adult day care have the system capabilities to meet the needs which have been identified; however, the funding support is not there to meet the demand. In general, funding for long term care services is increasingly in jeopardy.

On the institutional side of the spectrum, it is clear that there are two major barriers to nursing home care. First, there are not enough nursing home beds. While there is some question as to the actual number of beds needed, there is no doubt that many more beds are needed - particularly Level I/II beds for those persons requiring a higher level of care. Mentally ill elders, whether deinstitutionalized due to the Massachusetts Department of Mental Health's policy or other reasons, are impacting on the demand for available nursing home beds.

The current reimbursement system is the second barrier to nursing home care. Medicaid reimburses nursing homes below cost, thereby, creating a lack of incentives for nursing homes to admit these patients or expand existing facilities.

RECOMMENDATIONS:

The Health Care Delivery System Working Group reviewed the report of the Task Force on June 27, 1984 and unanimously voted to forward the report to the Greater Springfield Health Care Coalition along with the following recommendations to the Coalition and the community. The recommendations are grouped according to non-institutional and institutional sectors.

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NON-INSTITUTIONAL:

1. More non-institutional alternatives such as congregate living facilities, hospice/palliative programs, adult foster care, HMOs, and adult day care programs should be developed in the Greater Springfield Area. While exact numbers are beyond the scope of this report and should be monitored by the Western Massachusetts Health Planning Council and the state, we call upon those bodies and upon local providers of service to stimulate formation and/or expansion of programs to meet the clearly identified and growing community need.
2. Consideration needs to be given to the appropriate allocation of funding for long term care services. Additional funding should be pursued at the federal, state, and local levels. We call upon the Commonwealth of Massachusetts, our elected federal officials and various third party payors to immediately review reimbursement programs and policies in order to eliminate disincentives for formation and operation of needed long term care services.
3. We call upon the Health Care Coalition and the Greater Springfield Chamber of Commerce to stimulate understanding of and employer support for the social and medical programs offered by health and human service agencies working with the elderly.
4. The Health Care Coalition and the Springfield Chamber of Commerce should stimulate the investigation of the development of innovative programs to meet the needs of those in the work force. These programs should include, but not be limited to, pre-retirement seminars and counseling, part-time employment opportunities, and comprehensive benefit packages for older workers.
5. Health and social service agencies hav ıe responsibility to be innovative and cost-effective in offering services to elders.
6. It is essential that institutional services not be reduced or constrained until community services are developed and proven able to meet the needs.

INSTITUTIONAL SERVICES

1. The Greater Springfield Health Care Coalition should call upon the Commonwealth of Massachusetts to review those elements in Medicaid reimbursement which could provide disincentives to development of an appropriate mix of services and programs and to discrimination against admittance of Medicaid recipients and make those changes necessary to more equitably reflect the true costs of nursing home care and provide incentives for the admittance of Medicaid recipients.
2. Further consideration should be given to the development of public and private sector partnerships for innovative approaches to the funding of nursing home care.
3. In agreement with the Health Systems' Plan, there is a need for additional skilled nursing home beds, intermediate care beds, and rest home beds in Greater Springfield. Some consideration should be given to monitoring the future supply.
4. The number of chronic disease and rehabilitation beds in

Greater Springfield should not be increased. The existing beds and their role in the system should be constantly re-evaluated.

5. Programs should be developed to meet the needs of those patients who cannot be treated in the traditional institutional setting because they are violent, abusive, or require psychiatric services. The Coalition requests the active involvement of the Department of Mental Health in the development of such programs.

DISCUSSION:

Task Force members have identified several areas which lend themselves to further discussion - they are:

- Governmental support for congregate housing.
- Societal responsibilities towards the future payment of non-institutional long term care services.
- The potential for private insurance firms to develop and market long term care insurance that would provide extended coverage of home health and institutional services.
- The role and relevance of preventive health care throughout the health care continuum.
- The mandatory inclusion of home health care in health insurance programs.

While it is beyond the purview of this group to make substantive recommendations on these areas, we strongly encourage active discussion. □

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Medicine — A Perspective

The following is excerpted from the 1984 Annual Report of the President of the Baystate Medical Center.

It is increasingly apparant that health care providers and health care consumers (beautifully bureaucratic but also pitifully impersonal descriptive terms) must realize that in this day and age we can no longer have the best of all possible worlds. Compromises have to be made, and are being made.

It has been said that in the last ten years more changes in the health care industries have occured than in the preceding thousand years. There may be some exaggeration in this statement, but it contains a good bit of truth. We have never been closer to having health care regulated like a public utility. Whatever the final shape of medical care in the 90's and the next century may be, life will never be the same for most practitioners of medicine, as a consequence of the new emphasis on greater price sensitivity among the public, third party payors and business.

Health Maintenance Organizations (HMO's) are on the move. As of this writing, over eight percent of Americans are members of an HMO, and the percentage in Massachusetts is higher. It is estimated that by 1990, HMO's will have captured 20 - 25% of the health market. Health care industry and health care delivery are no longer separate entities; they are in the process of merging or have already merged.

The federal government realizes that under current law, the Medicare Hospital Insurance Trust Fund, as predicted by Health and Human Services Department actuaries, will be insolvent by 1990, — and this is based on a number of optimistic assumptions which may not come about, meaning that insolvency may occur before 1990. As a result, the federal government, while continuing rhetoric of deregulation and open market, is quietly and sometimes not so quietly moving forward with a strategy of more regulation, both of hospitals and medical practices. Earlier this year, there was talk that Congress would make Medicare assignment mandatory (i.e. meaning that physicians would have to accept Medicare payment as payment in full with no balance being permitted). There was even consideration that, in order to be eligible for Medicare payments, hospitals should have 100% Medical Staff participation in Medicare assignment. Such considerations have as yet not been written into law, but as of July, 1984, no increase in physician fee for services to Medicare recipients is permitted, subject to civil penalty! Physicians might as well accept Medicare assignment.

Most states now have a Diagnosis Related Grouping (DRG) prospective payment system for hospital charges. Congress has advanced to July 1, 1985, the due date for a Health Care Financing Administration (HCFA) report which would lump physician payment into a DRG based system. We may soon see the day when a single "global" payment is made to the hospital for each admission to include physicians' fees; at the very least we may see a single lump payment for physicians' services made to hospitals. The days of fee for service by

physicians seem numbered.

Federal law madates that by October 1, 1984, all Massachusetts Hospitals must have a contract with a statewide Peer Review Organization (PRO) to monitor length of stay and screen admissions of Medicare patients. As of this writing there remains the minor problem that no organization has as yet been designated; Massachusetts Peer Review, Inc., sponsored by the Massachusetts Medical Society, is no longer running. Increasing peer review activities will also be carried out by insurance companies, with the likely threat that insurance payment will be denied in case of non-compliance, to include pre-admission and pre-procedure reviews, intensified review of physicians' practice patterns, as well as intensified review of certain disease categories, and mandatory second opinion. When Rodney Dangerfield is told by his psychiatrist that he is crazy, demands a second opinion and is promptly told that he is also ugly, that may be humorous. But the increasing restrictions to the practice of medicine seem more ugly than funny.

In the United States, after years of searching for ways to assure availability of quality medical care for everybody, the last few years have brought us the agony of how to reduce escalation of the cost of medical care. Now we face the difficult if not impossible task to limit access and decrease demand for medical services, i.e. to ration medical care.

We physicians have always changed our medical practice pattern in response to scientific advances. We have gradually adopted a concern for shortened hospitalization. What is radically new and revolutionary is that our practice patterns are increasingly influenced by concerns for the solvency of the Medicare Hospital Insurance Trust Fund, profits for insurance companies, and hospital survivability.

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There may be an inherent conflict between the rationing of medical care and the oath of Hippocrates which states that physicians have a primary responsibility to their patients, — but we are told that in today's world this is no longer relevant. We must learn to balance demands for quality medical care against those of more reasonable cost. We must find and optimal balance between scientific medicine and affordability. We will, — there are no longer any alternatives.

Earlier this year, the American Medical Association recommended a voluntary freeze of physicians' fees. It should be noted that in Massachusetts physicians are already practicing under a "Quasi freeze", with Blue Shield having monopoly on the market, mandating that physicians accept Blue Shield payment as payment in full, a scheme now legalized by the Massachusetts General Court.

Physicians must be reasonable in their demands for recompense. But because of their substantial investment in a medical education including specialty training they should receive fair payment for their services and should not be forced back some 200 years when Benjamin Rush, one of the founding fathers of our contry said: "Resources of a farm will prevent physicians from cherishing, even for a moment, an impious wish for the prevalence of sickness in their neighborhood."

The public must be educated that there is on constitutional right to maximal medical care, and the public must realize that as long as we are forced to practice defensive medicine the cost of medical care will be high. It is to be hoped that Congress will enact the Moore-Gephardt "Alternative Medical Liability Act" which would bring some relief on the malpractice scene.

Let me share with you some provocative thoughts written by William R. Fifer, M.D., Clinical Professor of Medicine and Public Health at the University of Minnesota, published in the June, 1984 issue of "The Hospital Medical Staff." This article is entitled: "The Hospital Medical Staff of 1994", and speculates that:

1. The 1994 Hospital Medical Staff won't be a hospital Medical Staff because the hospital as we know it today will not be around in 1994. Hospitals will stop being "places" and become "things", must stop relying on further growth of inpatient services and must diversify their "product lines"; the hospital as an organization is undergoing a profound "reconceptualization".
2. Hospital Medical Staff won't be a Medical Staff. There are some 230 species of health care professionals other than physicians, outnumbering physicians 16-1. Their roles in the hospital will increase; it is only a question to what degree.
3. Hospital Medical Staff will be "defined" (it might as well be called a closed staff), to be derived from a strategic planning process.
4. The core staff of hospital-based practitioners will be larger and more diverse.
5. The hospital Medical Staff will be an organization, not just lip service as to "organized Medical Staff" and perhaps will be an incorporated Medical Staff.
6. The hospital Medical Staff will become part of "something bigger". Hospitals are joining large national organizations; it is fair to assume that Medical Staffs will be similarly affected.

7. The Hospital Medical Staff will be more closely bonded to the hospital either as part of a Health Maintenance Organization or Independent Practice Association or whatever joint venture may evolve.
8. The bond between a hospital and its Medical Staff will become monogamous; the days when a physician will be a member of multiple hospital staffs are numbered.
9. The Hospital Medical Staff will participate in both policy formulation and professional management of hospitals.
10. The Hospital Medical Staff will be entrepreneurial, involved with hospital in a variety of new business activities in the health care field.
11. The Hospital Medical Staff of 1994 will be capitated, that is, a fixed price is paid per month to assume the financial risks involved in the care of a defined population.
12. Physicians will become as much the managers of health care as the deliverers of such (gatekeepers).
13. The Hospital Medical Staff will still provide good medical care, having discovered that there is inevitably a trade-off between cost and quality. Physicians will deliver less care as traditionally measured (number of operations, number of inpatient days, length of stay, etc.), but with other modes of care available (home health, hospice, preventive medicine) quality should not be measurably affected (physicians will practice as much "caring medicine" as "scientific medicine").

How many of these predictions by Professor Fifer will come true by 1994 is subject to speculation, but I have no doubt that major changes will occur. □

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The "Nobility" of The Physician

The September 25th District Medical Society Meeting was a decided study in contrasts. We have noted elsewhere the large turnout and deep concern of physicians about the new changes in Medicare and the Deficit Reduction Act, with its yet unclear influence on patient care and financing. After dinner had been finished by physicians and spouses, together with over 30 area clergypersons at the Sheraton-West, the Rev. Msgr. Dino J. Lorenzetti reminded physicians of their "calling to Holiness". Coming from Buffalo, NY where he is the Family Life Director of the Archdiocese of Buffalo, he noted that change has been the order of things since he was ordained 32 years ago, including both religious and medical affairs. One thing that has not changed, he emphasized, was that physicians continue to be called to be witnesses to God's presence in the healing process and need to provide inspiration and care. Patients listen to a physician's every word, and the greatest word is "love". Msgr. Lorenzetti powerfully communicated his thesis that a physician was an agent of Christ's love to mankind by entering the lives of the sick with empathy and concern, communicating faith and vision. This constituted the "Nobility of the Physician," he maintained.

Perhaps a few physicians, still thinking about the new Medicare rules remembered the New Testament account of Peter and John's healing of the lame man on the Temple steps, where Peter said "Silver and gold have I none,..." □

W. J. Baker, M.D.

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Letters to the Editor

To the Editor:

Upon occasion, we have encountered problems with attending physicians being reluctant to address their valuable time to the responsibilities of pronouncing a patient deceased in the nursing home in a timely manner, particularly in a coverage situation.

It is our understanding when a physician declares him or herself to the attendance of a patient in a long term care facility that they will meet the standards set forth by the Commonwealth of Massachusetts, Department of Public Health Regulations concerning physician services in the facility including responsibility at time of death.

Perhaps you could be so kind as to place a reminder in the Hampden District Medical Society's journal, an item similar to the one here attached as a reminder to area physicians. It would greatly enhance the role of the nursing home administrators and nursing managers to have this problem minimized as the families of the deceased and the funeral home directors do not understand the facilities' responsiblity in this manner at such a difficult time.

It seems that professional level communication needs to be instituted to create an understanding of responsibility without involving the patients' families to be disturbed at such a critical time. □

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Jean M. Clifford
Administrator Heritage Nursing Home

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To the Editor:

As president of the Western Mass. Chapter of the Mass. Federation of Nursing Homes, I, from time to time, address problems that arise in the industry.

One such problem has been brought to my attention. This is an ongoing situation that is experienced by us all, in one degree or another.

The physician's responsibility is to pronounce patients that expire in nursing homes. This responsibility extends to the covering physician as well. Because nursing homes must be all things to all people, we not only have to keep doctors "happy" but also must function within the myrid of Rules and Regulations set forth by the Department of Public Health and the Federal Registry. The family considerations, and last but not least the patients. When a patient expires in a nursing home and is not pronounced by a doctor for 19 hours all the above mentioned are insulted.

I do believe all doctors are aware of their responsibilities.

I am enlisting your assistance in constantly communicating the importance of this responsibility to all physicians.

Sincerely,

Virginia F. Matosky
Western Mass. Federation
of Nursing Homes - President

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To the Editor:

As you know, the Health Planning Council is conducting a survey to determine the number and specialties of physicians practicing in Western Massachusetts. The survey form was developed with the help of James J. Siragusa, M.D., who is a member of our Board.

Aside from the fact that no one has done such a profile since our own in 1975, it is essential for planning purposes for all of us to know what the supply of physicians is locally. Most physicians believe that the Board of Registration in Medicine has all of this information already. Unfortunately that is not the case. Their manually recorded data is incomplete, out of date and virtually useless for planning purposes.

We frequently get calls from physicians thinking of locating in this region and are unable to give information on the supply in the area and can only refer them to telephone books to help them make such an important decision. We are often asked by government agencies about physicians supply and cannot give them accurate data upon which they can base important decisions.

Nor is there any way we can judge future need for physicians without an accurate picture of current practicing physicians.

The first mailing of the survey went out August 5, 1984 and the response rate so far is under 30%. We are asking your help in encouraging your members to reply. The form should not take more than 10 or 12 minutes to complete and, in fact, most of it could probably be completed by the office staff.

Because this information is so important we plan to do telephone follow-up if need by. But that is a most expensive and time consuming way to collect the data. We would appreciate any help you can give us.

Sincerely,

Herbert J. Hooven
Executive Director
Western Massachusetts
Health Planning Council

(MR. HOOVEN PRESENTED THIS PLEA TO THE HDMS EXECUTIVE COMMITTEE IN SEPTEMBER. THE EXECUTIVE COMMITTEE EXPRESSED ITS APPROVAL AND ENCOURAGEMENT OF MR. HOOVEN'S EFFORTS AND HAS INVITED HIM TO PUBLICIZE HIS EFFORTS IN THE HIPPOCRAT. — EDITOR)

Continuing Medical Education Program

SPEAKER:	ROBERT HUNT, M.D.
SUBJECT:	LASER SURGERY IN CLINICAL PRACTICE
DATE:	DECEMBER 10, 1984
WHERE:	PROVIDENCE HOSPITAL
TIME:	7:30 P.M.
CME DATA:	2 hours Category I, Springfield Academy of Medicine

Dr. Hunt is Clinical Instructor in Obstetrics and Gynecology, Harvard Medical School.

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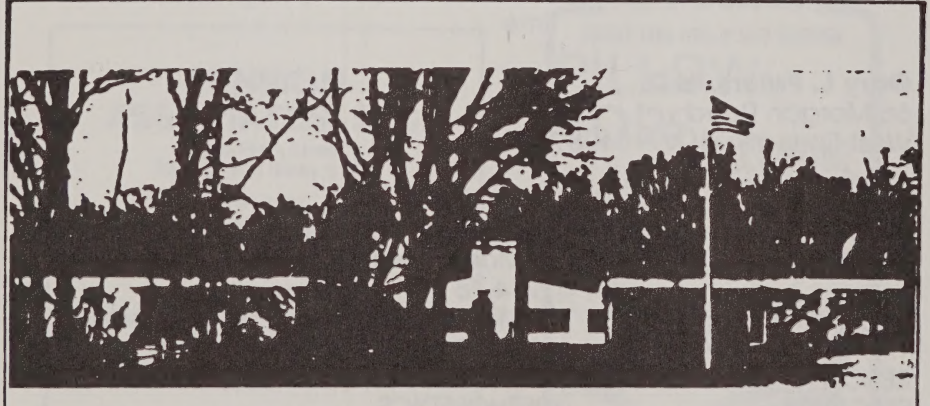
Continuing Medical Education Program

SPEAKER:	MICHAEL WICK, M.D.
SUBJECT:	MELANOMA
DATE:	NOVMEBER 12, 1984
WHERE:	PROVIDENCE HOSPITAL
TIME:	7:30 P.M.
CME DATA:	2 hours Category I, Springfield Academy of Medicine

Dr. Wick is Associate Professor of Dermatology, Harvard Medical School. Associate Physician, New England Deaconess Hospital. Chief of Dermatologic Oncology, Dana-Farber Cancer Center.



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MEDICAL:	University of Graz, Austria 1973-79
INTERNSHIP:	Schadmig, Austria 1979-80
RESIDENCY:	University of Maryland 1981-83
FELLOWSHIP:	University of Maryland Hospital 1983-84
SPECIALTY:	ANESTHESIOLOGY

Steven D. Kronick, M.D.
Baystate Medical Center
Springfield, MA 01107

BORN:	September 3, 1960
PREMED:	Union College Schenectedy, NY 1978-80
MEDICAL:	Albany Medical College of Union University Albany, NY 1980-84
INTERNSHIP:	Baystate Medical Center July-present time

Gary L. Peters, M.D.
66 Morgan Road
West Springfield, MA 01089

BORN:	June 17, 1953
PREMED:	Springfield College 1971-74
MEDICAL:	U. Mass. Medical School Worcester 1974-78
INTERNSHIP:	U. Mass. Medical Center, Worcester 1978-79
RESIDENCY:	U. Mass. Medical Center 1979-83
SPECIALTY:	ORTHOPEDICS

Douglas K. Hyde, M.D.
780 Chestnut Street
Springfield, MA 01107

BORN:	April 3, 1953
PREMED:	Colgate University Hamilton, NY 1971-75
MEDICAL:	SUNY Upstate Medical Center 1975-79
INTERNSHIP:	Norwalk Hospital, CT 1979-80
RESIDENCY:	Norwalk Hospital, CT 1980-82
SPECIALTY:	INTERNAL MEDICINE/GASTROENTEROLOGY

Donald Higby, M.D.
759 Chestnut Street
Springfield, MA 01107

BORN:	December 22, 1942
PREMED:	Catholic University of Washington, D.C. 1960-64
MEDICAL:	Stanford University School of Medicine 1964-69
INTERNSHIP:	St. Louis University Group of Hospitals 1969-70
RESIDENCY:	St. Louis University 1970-71
FELLOWSHIP:	Roswell Memorial Institute, Buffalo 1971-73
SPECIALTY:	INTERNAL MEDICINE/ONCOLOGY

Betsy S. August, M.D.
759 Chestnut Street
Springfield, MA 01107

BORN:	May 19, 1958
PREMED:	Brown University 9/76-6/80
MEDICAL:	Brown University 9/80-6/84
INTERNSHIP:	Baystate Medical Center - present time

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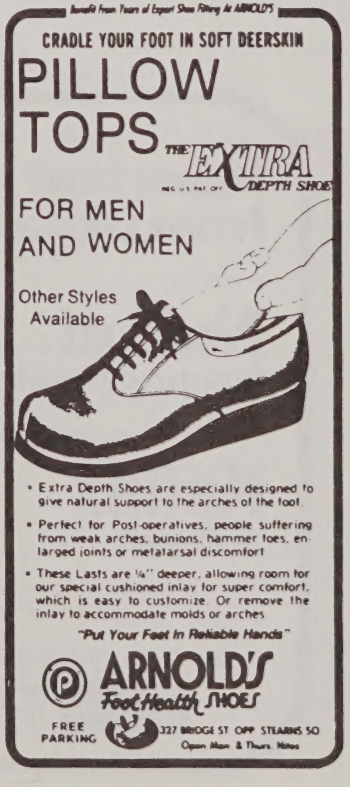
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Ronald E. Clement, M.D.
759 Chestnut Street
Springfield, MA 01107

BORN:	March 21, 1956
PREMED:	Colby College, Waterville, ME 8/74-6/76
MEDICAL:	Ohio State University School of Medicine 1976-78
	St. George University School of Medicine 8/80-10/82
	Hahnemann University Philadelphia 11/82-6/84
INTERNSHIP:	Baystate Medical Center - present time

Evelyn D. Heffernan, M.D.
16 Woodside Terrace
Springfield, MA 01108

BORN:	August 27, 1927
PREMED:	U. Mass. 1944-48
MEDICAL:	Tufts Medical School 1948-52
INTERNSHIP:	Beth Israel Hospital 1952-53
RESIDENCY:	Beth Israel 1953-54
	Bellevue Hospital 1954-58
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Executive Committee

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, September 17, 1984. The meeting was called to order by Dr. Lorne Smith, President, at 7:40 p.m.

Present were: Drs. Smith, Asinas, Remsberg, Ryan, Munro, Pacosa and Navazio; Mrs. Kiss, Mrs. Nystrom.

Invited Guests: Mr. Hooven and Dr. Delaney of Western Mass. Health Planning Council. Mrs. Margaret Stoler, Library Director, Academy of Medicine.

The minutes of the June 25, 1984, meeting were approved as printed. The Quarterly Financial report of the Academy of Medicine was accepted.

OLD BUSINESS:

1. **Physician Referral Service:** No action will be taken. It was felt that the problem was not acute at the present time.

2. **HDMS Yellow Pages Ad:** $726.00 will be spent, which is a one year special rate. This will provide a 1" ad under Physicians & Surgeons Information Bureau and a ½" ad placed alphabetically under Physicians & Surgeons - Medical. These ads will be in both Springfield and Holyoke directories. The monthly rates will be $39.50 for Springfield and $21.00 for Holyoke. (This physician referral service is a major contribution that HDMS makes to the welfare of our patient population and for the benefit of our physician members. — Editor—)

3. **Infant Mortality Rate Report:** The infant mortality rate question will be forwarded to the Public Health Committee for study.

NEW BUSINESS:

1. **Variations in Surgical Utilization in Mass. Communities;** Mr. Hooven and Dr. Delaney reviewed the study from its inception to the present. He stressed that this was a one year study and though the data was carefully compiled, it is not enough to be able to find any strong conclusions. However, it will be replicated from year to year.

It was decided that a special HDMS committee will be appointed by Dr. Smith to study the report.

2. **Reinstate AMA Religion & Medicine Committee:**Dr. Fitzpatrick's letter was read and approved. A letter will be sent to Mass. Medical Society asking their help in getting this AMA committee reinstated.

3. **Medicare - Reimbursement Contract:** Neil Foley and George Roy of MMS will be at the District Meeting on September 25th to discuss the contract and answer questions.

4. **Rheumatoid Disease Foundation:** It was decided to send the material to the AMA and ask them to check it out and see what can be done about it. A letter will be sent to Dr. Antiles informing him of the committee's decision.

5. **Senatorial Debate:** It was suggested that a senatorial debate could be sponsored on TV, with health issues as the topic. The committee authorized Drs. O'Neill, Ryan and Smith to proceed with planning of the debate.

6. **Vial of Life:** Formal endorsement and sponsorship will be given to this program. Letters will be sent to each area hospital asking them to consider the program. (The Vial of Life program encourages elderly persons to keep a vial containing their pertinent medical information in a predesignated spot in their refrigerator where it can be found in the event of a medical emergency. — Editor—)

7. **Public Relations Intern:** Permission was given to Mrs. Nystrom to apply for a University of Massachusetts Public Relations Intern.

8. **Mass. Health Science Library Network (MaHSLin):** Mrs. Stoler reported that the MMS Publications Committee is considering setting up an electronics communication and mail system throughout the state. Mrs. Stoler said the next meeting at MMS will be September 26th and she will keep the Executive Committee informed.

9. **Public Hearing on Usual and Customary Fees:** State Commissioner of Insurance, Peter Hiam, will conduct a pre-hearing on September 29th and the Hearing on November 27th. The MMS is preparing a presentation and planning to participate.

10. **Public Hearing on Access Problems for Medicaid Recipients:** Mr. Hooven said that health systems agencies across the state have been asked to hold Public Hearings on access problems for Medicaid recipients. This hearing has been scheduled for Oct. 11th at 7:30 p.m. at Springfield Municipal Hospital's Conference Room. Dr. Siragusa will be a member of the panel accepting testimony. The Public Hearing will be announced at the September 25th District Meeting. Dr. Smith will plan to attend. Dr. Tauber will give testimony.

11. **Executive Committee Meeting Date:** Mrs. Stoler will check to see if the Academy's CME Program could be changed. If not, the Executive Committee could be changed to another day during the third week of the month.

12. **PRO Update:** Our local PSRO could be made a part of the Eastern PRO. Dr. Smith warned that should the system collapse, HDMS could be asked to furnish doctors to do Peer Review, and some activities of the Present PSRO may be merged into HDMS.

Dr. Smith thanked Mr. Hooven, Dr. Delaney and Mrs. Stoler for attending and participating. There being no further business, the meeting was adjourned at 9:45 p.m.

Respectfully submitted,
Carol Nystrom
Executive Secretary

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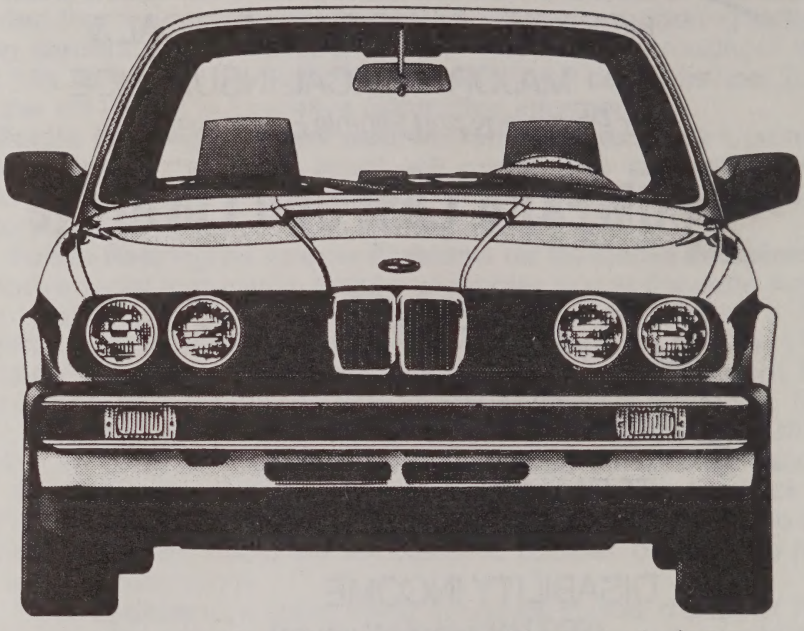

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